How do people cope with acute mental illness in their loved ones? p 1086

The failure of modern textbooks

PERSONAL VIEW **Roger K Allen**

I was recently asked by a colleague overseas to coauthor a chapter on the treatment of sarcoidosis for a book on interstitial lung disease. However, the task competes with a book I am writing about my early childhood and in which I am very much aware of the "voice" of the book. I have not yet started the chapter of the textbook but have looked at some early editions.

The overwhelming thing I observe is the failure of most modern textbooks to convey personal experience, except by virtue of a citation of some prior publication. The voice, by convention, is scientific, impersonal, passive, and not active. It is far off. The patient and the medical process are viewed like an enemy frigate through a spyglass at a league's distance, only even less emotive. A handbook I own, *Evidence-based Medicine Toolkit* (no definite article), is the medical equivalent of a metre long bar of platinum held in a vacuum in Paris by which all metres and hence evidence in the medical cosmos is to be measured.

I believe the duty of a textbook is to be enjoyable to read. Most, however, have the linguistic flair of a German car manual; they have no sense of engagement with the reader, no real human "voice," no guides for the novice, no hints to help you remember indigestible facts, no etymology to explain words, no history of the disease, treatment, or investigations. In short, they are written by idiot savants devoid of wit and soul. Their words are not used like notes, and their sentences are constructed with the finesse of an amateur brick layer. This is pedestrian prose at its worst. *Harrison's Principles of Internal Medicine* reads like a medical version of the *Larousse Gastronomique* only with less appeal, and the only way I find it interesting is to read the French version, which then subserves my two needs: consciousness and information.

We have thrown the baby out with the bath water. If I wrote a chapter on the treatment of sarcoidosis I would like to include information about the history of the drugs used, the problems I have personally encountered over 30 years, and the pitfalls and costs—and not just lifeless lists of studies and facts like a Metro timetable. I wish to engage with my reader and share the passion I have for the subject of sarcoidosis. Alas, I am sure the editors would fillet the fish, leaving only the skeletal remnants, in accordance with the doctrine of Cochrane and the medical and political correctness of the time.

Carl Jung, in his *Psychology and the East*, stated: "Science is the tool of the Western mind, and with it one can open more doors than with bare hands. It is part and parcel of our understanding, and it obscures our insight only when it claims that the understanding it conveys is the only kind there is. The East teaches us another, broader, more profound, and higher understanding—understanding through life."

The history of our craft is missing, even as a preamble, from our textbooks, which are preoccupied with the latest creations—advances and the studies and trials that led to them—and give no sense of the fertile swamp from which these new reptiles have arisen. This year's textbook will be next year's door stopper and no more readable.

I recently asked a final year medical student whether he knew who discovered oxygen, the derivation of the word "oxygen," and the first man to describe how the lungs work. He did not know. Thus I believe that the current teaching of medicine perpetuates the existential, mechanical style of modern journals and textbooks.

Let us rediscover charm, linguistic style, and humour to breathe new life into these dreary reductionist manuals on the human machine. Be like Dr Johnson, whose *Dictionary of the English Language* stands out from all dictionaries that followed not just by his vast eclectic knowledge but by its humour, prejudices, and views of life.

So don't give me the chaff of a modern textbook to read. Nay, Sire, give me a bushel of oats.

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REVIEW OF THE WEEK

A far from fairytale romance

How do people cope with acute mental illness in their loved ones? They don't always get a happy ending if this play, which **Richard Hurley** saw, is anything to go by

The slick but solemn *Polar Bears* tells of an intense romance that ends in catastrophe despite the best intentions. This first play by Mark Haddon, author of the top selling novel *The Curious Incident of the Dog in the Night-time*, considers what life is like for those who live with and care for people who have severe mental illness.

Kay, an aspiring children's writer, has a bipolar spectrum disorder. In good times she can be energetic, rude, funny, and full of optimism. But in bad times she can be consumed in fantasy and lost to another world. She has a new found partner—John, a caring and loyal philosophy lecturer. He wants to love and to help her, but Kay's mother and brother are cautious: they've seen all this before. John is just another in a string of men, and her mother and brother know that beyond the romance lies the reality of Kay's illness, which will test John's promises and his love to the limit. And it does: *Polar Bears* starts with John's gruesome confession that he has killed Kay four or five days before and that she's rotting in the cellar. Whether this is true or not, it seems that John may well be ill as well.

Haddon's narrative is fragmented in time, with the play starting some time after Kay's death. From here it jumps chronologically: scenes depicting Kay's sudden manic highs are juxtaposed with calmer moments. This disjointedness and unpredictability perhaps reflects something of the nature of bipolar disorder, at least for those who observe it. And it's unclear which if any of the sequences occur only in Kay's mind. Those enshrouded in dry ice, showing her sharing flapjacks with a Jesus figure with a Geordie accent, are probably delusions. Are her telephone monologues about Norwegian polar bears and Munch's famous painting *The Scream* messages to John, or are they conversations exclusive to Kay's mind?

The play focuses mostly on Kay's manic episodes rather than her depressive ones, and it largely omits any more level moments in between. When Kay stops taking her prescription drugs things start to go wrong. John's love is no longer enough to keep her from sleeping outside in the wet, from ending up in hospital, from running back to a former lover and spending three days in his bed.

During one of Kay's spiralling highs she convinces John that she has talent as an artist and has been shortlisted for a prize for a children's book that she has written and illustrated. Kay's mental state deteriorates; and, against John's wishes, she insists on visiting Oslo for book signings and school visits. But John finds out from her mother that Kay has no aptitude for art at all. Pages of Kay's drawings flutter down from the ceiling, paralleling John's world crashing down, as he realises that he's been swept along in her fantasy. "This is what it's like, John. You think you know someone," Kay's mother says.

Polar Bears
A play by Mark Haddon
Donmar Warehouse, London
Until 22 May
www.donmarwarehouse.com/pl109.html
Rating: ★★★☆

Haddon leaves us never quite sure where reality stops and fantasy begins. In one scene Kay tells a fairy story about a girl who has a twin monster. The monster dies and the girl keeps its white fur. She grows up and marries a prince, but every so often she slips into the monster's fur. One day she has no more need for her own skin and leaves it behind. Then, "growling, stamping, and gnashing," she leaves her prince. Is this Kay's winning children's story or an allegory for her mental state or both? As Kay's illness drives John into frenzy, we're given other fragments of stories to try to knit together. We find out that when Kay was a girl her father hanged himself while in mental turmoil. In another scene a young brother forces Kay to recite their father's suicide note while standing on a chair, a noose around her neck.

Haddon has taken a new direction with the medium of theatre, but he's still looking to mental illness as the inspiration for, and the subject of, his work. His 2003 novel *The Curious Incident of the Dog in the Night-time* was narrated by a boy with Asperger's syndrome (*BMJ* 2003;327:815). And his second novel, *A Spot of Bother*, published in 2006, was about hypochondria.

Polar Bears paints a stark picture of the effects of bipolar disorder on those who care for affected partners or family members. John's well intentioned promises seem arrogant: his love was not enough to temper, let alone cure, Kay's psychological illness. Haddon's sharp writing is tender and surreally funny in places, and his use of a non-linear dramatic structure reinforces the erratic nature of Kay's illness. *Polar Bears* operates in extremes—from a fantasy love affair, through the nightmare of killing your lover, to discussing with Jesus the stages of a dead body's putrefaction. And although these stories are certainly well crafted and engaging, how real a reflection they are of the stories of a typical patient with bipolar disorder is open to question.

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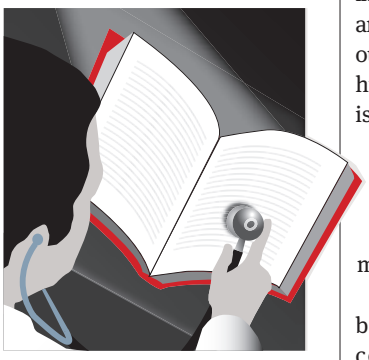
The spur of death

BETWEEN THE LINES
Theodore Dalrymple



I used to watch mourners at funerals from my study window that overlooked a splendid church. Most of the mourners—the men, anyway—furtively looked at their watches, consulted their diaries, or sent text messages, as if funerals were . . . of no possible application to them

However many times one swears not to leave matters to the last possible moment, one's resolution is never kept; the lecture that one has agreed to give next Tuesday remains unwritten until Monday evening. There is nothing like a little panic to concentrate the mind wonderfully.

Deadlines are not called deadlines for nothing. The term hints at the suspicion that without the prospect of death we should never get anything done. Everything could wait for another few centuries; nothing would be urgent.

Valuable as death may be as a stimulus to human effort, however, it is an uncomfortable subject for human minds. La Rochefoucauld said that neither the sun nor death could be stared at for very long, and a little collection of stories about death by Emile Zola (1860-1902), the great French novelist, called *How We Die*, shows that this is so.

Like the registrar general, Zola divides his society into five, in Zola's case the classification consisting of the aristocrat, the bourgeois, the shopkeeper, the working class unemployed, and the peasant. His stories consist of sketches of how each of them dies.

Zola was himself to die a dramatic death, suffocated by a fire in his Paris bedroom. He is said to have staggered towards the window in an attempt to get air but collapsed before he could get there; his wife, though later revived, was unconscious and could not help him. There have been rumours ever since that it was murder, carried out by his many enemies; but this seems unlikely, as suffocation by a domestic fire is rather difficult deliberately to arrange.

The deaths in *How We Die*, however, are all unremarkable, raising no suspicions of foul play. Doctors are called in the first four cases but are, of course, quite useless; in the last, an old peasant aged 70 dies without the permission of his doctor because it is harvest time, and the time of none of the family can be spared to fetch him from several miles away.

La Rochefoucauld believed that we couldn't contemplate death for long because the prospect of personal extinction was too painful for us; for Zola, however, it derived from the fact that we are too rooted in the concerns of everyday life for it to preoccupy us for long. The three sons of Madame Guerard, who dies after a short illness, genuinely love their mother and cry at her death; but a far more prolonged and consuming consequence of her death than grief is struggle over the inheritance, which all of them (wastrels in one way or another) badly need.

But the death, or rather the burial service, that had most effect on me was that of le Comte de Verteuil. The mourners soon grow bored at this service. They think and talk of business, love affairs, gossip. One of them reads the inscription on another grave—"the qualities of heart, generosity and goodness"—and murmurs, "Oh, I knew him, he was a complete swine."

I used to watch mourners at funerals from my study window overlooking a splendid church. Most of the mourners—the men, anyway—furtively looked at their watches, consulted their diaries, or sent text messages, as if funerals were primitive ceremonies conducted by a strange tribe (the dead) of no possible application to them. We need death to spur us on to effort but also a sense of time remaining to us to make that effort.

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MEDICAL CLASSICS

Essays By Michel de Montaigne

First published 1580

Some ideas seem to hover just beyond the horizon of possibility. Try to imagine modern medicine without our idea of "the self," without the idea that we each possess a unique, authentic, evolving identity—an inner core, unlike all others, the essence of who we most deeply are. Depth psychology, narrative medicine, person centred care, a "good death": the language of medicine has increasingly aligned itself to the powerful gravitational field of the self. It wasn't always this way. Our idea of who we are is one of the great works of modernity, and it takes considerable mental cunning to see it as anything other than normal or natural.

In 1580 the French late Renaissance writer Michel Eyquem de Montaigne published the first book of his *Essays*. Not only did he define a genre: it is probably only a small exaggeration to say that he also midwifed our idea of the self. Where the ancient world had largely seen human nature as static, founded on God or nature, and approached through reason or prayer, in his *Essays* Montaigne turned his attention to himself. "I want to be seen here," he writes in his address to the reader, "in my simple, natural, ordinary fashion, without straining or artifice; for it is myself that I portray."

There had been journals or diaries before but these were often formal, recounting great deeds or historical events, theorising in the abstract. Montaigne was after something different. "The world always looks straight ahead; as for me I turn my gaze inward . . . I continually observe myself, I take stock of myself, I taste myself . . . I roll about in myself." In 1571, tired of Bordeaux politics, he retired to his chateau, intending to devote himself to contemplation. Initially at least it was not a success. Left to his own devices he was forced to confront his own mind. To use his metaphor, it was as steady as the beams flung on the ceiling by a sunlit basin of water. To counteract melancholy he started to write. His project: to trace those beams as they flicker and lurch.

Montaigne: inspiring

The novelty of the subject required a new genre. In French "essayer" means simply to try, to give it a bash. Forget the dull structure of school essays, with their tiresome beginnings, middles, and ends. Montaigne's essays are quick, brilliant, erratic, and evasive, seldom pausing long enough even to address the title he set himself. Three sympathetic qualities ripple through them: curiosity, tolerance, and scepticism. Montaigne was interested in everything, forgave much, and doubted always.

Illness has many faces. It can be viewed from a bewildering range of perspectives, glimpsed from a thousand windows. But one thing it will always be, for somebody, is personal. A diagnosis of cancer, the failure of an organ, the decay of a mind: however we choose to describe them they will always also be somebody's tragedy, somebody's nightmare. Modern medicine, like modern life, is inconceivable without our idea of the deep self, of the suffering human subject. Doctors, it is increasingly recognised, need to understand this human experience of illness, to understand the subject's journey through medicine. To this end they could do far worse than read Montaigne and go back, in pleasurable company, to one of the sources of the self.

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Bad medicine: chlamydia

FROM THE FRONTLINE
Des Spence

Health promotion messages often stitch together mismatching research. Then, given two million volts of advertising, the facts take on artificial life. This is the story of chlamydia, facts marauding through the columns of magazines, using fear to sell print copy. The horror story is that chlamydia inevitably causes infertility—a terrible monster. So my time is spent reassuring young women that it doesn't. But there is always dissonance: they are never reassured, and their eyes smoulder with recrimination.

Here is the case for chlamydia screening. Infection rates are exploding, more than doubling in a decade. The prevalence in young people is 10% (some reports suggest it is even higher), and chlamydia causes pelvic inflammatory disease (PID) and, in turn, infertility. A widely quoted statistic was that untreated chlamydia progressed to PID in 40% of cases. Also, treatment is simple, if it is started early. These "facts" met many of the criteria for screening. Indeed, observational data from other countries and mathematical modelling indicated that the prevalence of PID would fall after screening was introduced.

But this story is too simple and is infected with confounding and conflicting evidence. The introduction of non-culture techniques for testing for chlamydia allowed self sampling that substantially improved acceptability and sensitivity of results. So the observed "alarming" rapid increase is likely to be mere artefact, down to more and better testing. Even if (a big if) the observed increase in incidence is real, then surely we would see a doubling in PID, but we have seen a decline in PID during this period.

Also, the widely quoted statistic that 40% of untreated chlamydia progresses to PID is intuitively wrong. If we extrapolated the numbers, then 4% of the young population would have PID at any given time. Consider also that chlamydia clears spontaneously over time, so if we take a conservative point prevalence of 10%, then lifetime incidence must in fact be 2-3 times that or higher. Lastly, PID itself is poorly defined, with no gold standard (even the trial recently published in the *BMJ* used data based on the term "possible PID," reflecting vague abdominal pain, and is caused by a poorly understood combination of infection and inflammation. Furthermore, no evidence indicates that screening directly reduces infertility, the only important end point.

We simply don't understand the natural epidemiology of chlamydia. Indeed the only conclusion is that chlamydia must have been highly prevalent but undetected for generations. Current opportunistic screening is not working in the United Kingdom.

So screening must either be more systematic (but we don't know whether this will work) or should stop. Chlamydia is a story of hysterical communication and poor evidence, leaving a generation fearful of future infertility (haunted by "silent PID") and needlessly destroying countless young vulnerable relationships—just bad medicine.

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Consumer receptive alternative preparations (CRAP)

THE BEST MEDICINE
Liam Farrell

Joe was a veritable cornucopia of symptoms and a technicolour array of risk factors, and I looked out the window in the despairing hope that the clouds might form themselves into a plausible diagnosis. They did their best, amusingly shaping themselves into a pair of rather ripe and Rubenesque buttocks that might have tempted even a post-therapy Tiger Woods, but I had just about given up when a bus rolled by with a big advert on the side, and I stood like stout Cortez, silent upon a peak on Darién.

Aristotle and Spinoza believed that all human behaviour is self referential, and boy were they right. I was being selfish; I had kept Joe all to myself. It was time to share; he had delighted me long enough.

"Have you considered trying a health food shop?" I asked.

"I heard they sold crap," he said.

"Perhaps," I said, "but not just any old CRAP, it's brightly coloured, attractively packaged CRAP. Even better, according to the ads, it's half price CRAP."

"I note," said Joe perspicaciously, "that the word 'CRAP' is a recurring theme; you have used it three times already."

"What I tell you three times is true," I protested.

"Presenting Carrollian nonsense instead of a solid evidence base is not a persuasive argument," said Joe.

"Look," I said, not giving up, "Go into any high street pharmacy and you will see row upon row of homoeopathic preparations, vitamin and mineral supplements, and flower remedies, some of them used for thousands of years by a rainforest tribe who survive on a diet of honeydew and possum sweat. Now remember, because this is important: pharmacists are highly trained healthcare professionals, and surely it would be against their ethical code to stock and thereby give implicit approval to treatments that have not been proved to be effective."

"And yet," said Joe, refusing to display an open mind, "the pharmacists claim that there is a consumer demand for these products. So they stock homoeopathic products purely because they sell, not because they work."

"But you can't overdose, and they're very safe," I tried one last time.

"Yes," Joe admitted grudgingly, "You can't have too much CRAP."

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